

# Children and young people's health – where next?



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# Executive summary

Children and young people's interests must be at the centre of health and local authority services. The current health and local government reforms present significant opportunities in this area but there has not been sufficient focus on how the new structures will work to improve children and young people's health.

Child health is of crucial importance to the future of the NHS, public services and the national economy. However, proportionally less money is spent per capita on children's health services than on adult health services and the UK is lagging behind the rest of Europe on key child health indicators.

Based on an event facilitated by the Royal College of Paediatrics and Child Health and the NHS Confederation, with support from the Office for Public Management, this report highlights the key challenges and proposes solutions.

It makes the following key points:

- Investment in children's and young people's health improves long-term outcomes, is cost effective and reduces pressure on the health service.
- A cross-government strategy should be developed to provide a clear vision for improving the health and well-being of children, young people and families.
- The reformed NHS will need to ensure quality of care across care pathways and different providers to avoid fragmentation in the new system. The Government needs to be explicit about where accountability lies for child health and child public health.
- The Government's health visitor programme should focus on achieving outcomes and ensure that recruitment of health visitors does not dismantle effective multi-disciplinary/professional teams that address prevention, early intervention and quality joined-up care for children aged 0 to five years.
- Collaborative joint working and aligned budgets must be in place to reap the cost and quality benefits of integrated services for children.
- Greater alignment is required between child and adult health services.
- Support for local cross-discipline engagement and sharing good practice is crucial.
- Clinician-led commissioning should be informed by evidence to improve outcomes cost effectively.
- Robust IT and integrated data collection systems and sharing protocols are crucial to effective joint working.

Children and young people should have a louder voice in influencing how services are organised and delivered, as well as a greater say over their personal health choices.

See our accompanying publication, *Engaging and involving children and young people in health services*, available at

[www.nhsconfed.org/publications](http://www.nhsconfed.org/publications)

# Background

The health and local government reforms coming into force in England will significantly affect how child health services will be commissioned and delivered. Yet, throughout the Government's health reforms, children's needs and aspirations have rarely been discussed and the capacity of the Departments of Health and for Education to focus on children and young people has been reduced.

Investing in children's and young people's health is a cost-effective way of improving long-term health outcomes and reducing pressure on the health service as these children grow up. While it is clear that the NHS needs to find efficiency savings, disinvesting in child health and well-being will cost health and other public services more in the long term.

Significant improvements in child health have been made over the last five years, but unless children's and young people's needs are brought into focus, the current reforms have the potential to undo much of this good work.

This report outlines the key priorities for child health as the NHS and local government reforms are implemented. Developed in partnership with child health professionals in the NHS and local government, it takes into account views from clinicians, managers, commissioners and providers across the NHS.

**“Investing in children and young people's health is a cost-effective way of improving long-term health outcomes and reducing pressure on the health service as these children grow up.”**

## Child health and well-being in the UK

The UK has higher all-cause childhood mortality than many other European countries.<sup>1</sup> Children and young people in the UK also have worse health and well-being outcomes than their European counterparts due to a multitude of social and economic factors.

The profile of child health within the NHS in England has risen in recent years. Numerous reports such as the Graham Allen reviews on early intervention (2011)<sup>2</sup>, Kennedy review regarding cultural barriers within the NHS (2010)<sup>3</sup>, Marmot review of health inequalities (2010)<sup>4</sup>, Munro review of child protection (2011)<sup>5</sup> and the green paper on special educational needs and disabilities (2011)<sup>6</sup> demonstrate a national commitment to improving child physical and mental health and well-being. However, many of the recommendations raised in these reports have not yet been implemented.

Despite the range of child health policies and strategies within individual government departments and ministries (such as palliative care, young people's access to psychological therapies and the Healthy Child Programme) there is still no sufficiently detailed cross-government strategy for improving children and young people's health.

The determinants of adult health, obesity and chronic conditions such as hypertension and diabetes mellitus, as well as other causes of health inequalities, have their roots in foetal and early infant life. Commissioning for a healthy life across the life-course must start from maternity care pre-birth, with close attention to family and environmental factors continuing into adolescence.



Recent steps to strengthen a multi-disciplinary children's workforce and closer working between the NHS and local authorities, including schools and the police, have led to improvements. Health service providers and staff are increasingly aware of their roles and responsibilities such as safeguarding and the limits of confidentiality.

The NHS has also started to engage and involve children and young people more in service delivery and commissioning – a publication accompanying this report provides more detail regarding the importance of participation. However, reports and recommendations need to be implemented to ensure that improvements in child health over the last few years are not eroded. A cross-government strategy for children and young people's health is desperately needed to bring positive initiatives together and ensure all parts of government, nationally and locally, are working towards the same goals.

## Recommendation

- A cross-government strategy should be developed to provide a clear vision and sufficient detail for improving health and well-being of children, young people and families. This strategy should connect the reforms and new systems together and incorporate the recommendations from recent key policy reviews and strategies across the life of a child, from maternity care pre-birth to 18 years, and beyond into adulthood. The Government should allow time for the new strategy to be implemented in order to measure progress.

**“A cross-government strategy for children and young people's health is desperately needed to bring positive initiatives together and ensure all parts of government are working towards the same goals.”**

# Commissioning quality and outcomes

Proportionately less money is spent per capita on children's health services than on adult health services. There is no longer a requirement for local government to invest in youth services and the reduction of local authority budgets is expected to result in cuts to early years and youth services of more than 20 per cent in real terms.<sup>7</sup>

Joint commissioning between the NHS and local authorities has joined up care pathways for children and young people in many local areas, for example in diabetic care or addressing behavioural problems. This has resulted in better outcomes and improved partnerships between different commissioners and providers. Health professionals are increasingly providing services in non-health settings such as children's centres, and commissioning of multi-professional teams is becoming more common. Such changes are proving effective, with reports of a positive impact on outcomes and morale.

Under the health reforms, however, six different parts of the system are likely to be responsible for commissioning child health and child public health services (see Table 1 on page 6). This potential increase in complexity may make it more difficult to join up commissioning efforts between local, sub-national and national commissioning bodies.

Health and wellbeing boards have a proposed duty to develop a Joint Strategic Needs Assessment<sup>8</sup> and a joint health and wellbeing strategy. These are crucial processes and documents for setting the overall local framework for improvement in children's and young people's physical and mental health and well-being across local commissioners. It is important for all partners on the health and wellbeing board to support the strategy in order to commit resources, commission according to agreed priorities and monitor progress.

It remains unclear which part of the system will commission designated safeguarding or

looked after children professionals in the health service, although it is hoped this will become clear in the accountability framework (due to be published jointly by the Department of Health and Department for Education in early 2012).

It is also unclear how the effectiveness of commissioning will be monitored, but it is expected to be within the NHS Commissioning Board local team function.

**“Health professionals are increasingly providing services in non-health settings such as children's centres.”**

## Holistic approach

Outcome measures (such as those included in the Quality and Outcomes Framework and the Public Health and NHS Outcomes Frameworks) alone cannot account for the full range and complexity of child health provision, such as long-term conditions. A holistic approach is needed to understand how effective services are across a range of interventions.

Services for children and families must therefore not be designed solely around high-level indicators but developed to incorporate wider factors that have an impact on physical and mental health and well-being, such as housing and education, and reflect a shift in focus towards improving mental and physical well-being and not just illness.<sup>9</sup>

Addressing the broader determinants of health, such as education and housing, will require shifts in medical responses. Child health should not be considered to be just about healthcare delivery and specialist paediatric services but about building a healthier population for the future.

**Table 1: Six levels of commissioning health and public health services for children and young people**

|                     | Body                             | Responsibilities   |
|---------------------|----------------------------------|--|
| <b>National</b>     | 1. NHS Commissioning Board       | Commissioning specialist NHS services, including some mental health and acute care within managed clinical networks; child public health, including the Healthy Child Programme for under-fives (health visitors) until 2015 when it will move to local authorities; healthcare for young people in custody; and immunisation, core pharmacy and primary ophthalmic services. Some of these functions may be commissioned sub-nationally.  |
|                     | 2. Public Health England         | Responsible for national public health campaigns and health protection nationally and locally and will host specialist expertise such as dental public health. Public Health England will have local 'units' for those functions which depend on close relationships with local government and four geographical hubs will be coterminous with the NHS Commissioning Board and Department for Communities and Local Government resilience hubs.  |
| <b>Sub-national</b> | 3. NHS Commissioning Board       | Likely to commission the GP contract which includes primary care, contraception and sexual health services. However, these could happen at a different level.  |
| <b>Supra-local</b>  | 4. Clinical commissioning groups | May work together with local authorities to commission those specialist services for which they are responsible, where commissioning over a larger geographical area may be more effective, such as healthcare for looked after children, provision for disabled children and those with complex or high-cost needs.<br><br>To achieve this they may cluster to align with local authorities.  |
| <b>Local</b>        | 5. Clinical commissioning groups | Commissioning local child health and maternity services in acute and community settings.   |
|                     | 6. Local authorities (LAs)       | Commissioning the child public health services, including the Healthy Child Programme five to 18 and school nurses. Commissioning the majority of other public health services including: dental public health, tobacco, alcohol and drugs, public mental health, accidental injury prevention and sexual health services. LAs will take over commissioning for 0 to five child public health including the Healthy Child Programme and health visitors 2015 onwards. Schools may also commission elements of special education needs services and other school health initiatives that local authorities do not commission. This might be particularly pertinent in free schools and academies. |



## Joining up care pathways

A potential fragmentation of service design could affect healthcare quality and patient experience. Accountabilities for quality and outcomes, including across boundaries and between services, must be clearly defined. The biggest risk to quality of care occurs at transitions, when patients move from one service to another, such as from adolescent to adult services or from primary to secondary care. The future NHS model will need to establish which part of the system is responsible for ensuring the quality of a whole pathway of care and identifying gaps in service or poor quality handovers between providers.

The possible loss of general practice boundaries has uncertain implications for integrated service provision. While clinical commissioning groups will be encouraged to be coterminous with local authorities, practice patients who are located far from their GP may fall within a different population boundary. Liaison with other authorities or services, including child protection, social care, education and the youth justice system, may be required. This could reduce the potential benefits for joint, integrated and collaborative commissioning.

Effective local authority commissioning for services, such as social care support for specialist placements for those prone to self-harm or alcohol and substance misuse, could help to improve outcomes across the health economy.

**“The biggest risk to quality of care occurs at transitions, when patients move from one service to another.”**

## Overseeing quality

Personalised health and care packages, through personal budgets, can help make the provision of care more coherent, empower patients through devolving rationing decisions down to the individual and potentially increase choice for patients. However, we believe safeguards need to be in place to ensure that this does not become overly burdensome for the user or their families. Some of the services individuals purchase may not automatically be covered by Care Quality Commission registration standards and this could lead to a lack of oversight of the quality of these services. We believe that more needs to be done to ensure that the regulatory system retains the oversight of quality in these cases.

## Improving the system in transition and beyond

Maintaining quality during the transition to the new structures is essential. Clinical commissioning groups and local authority staff will need the right skills and knowledge to commission using a service-user and rights-based approach. They will also need to maintain an awareness of the importance of safeguarding responsibilities underpinning all contracts. GPs as providers may need incentives to:

- prioritise and improve the range of primary care available locally for infants, children and young people, while improving care of chronic long-term conditions and bringing care into the community and closer to the child
- include children and young people with long-term and chronic conditions such as asthma, diabetes mellitus and epilepsy in the Quality and Outcomes Framework (QOF)
- improve palliative care for children through their life course

- strengthen the general practice contribution to the Healthy Child Programme by ensuring appropriate child health screening competencies become a contractual requirement
- implement access to mental health and well-being services
- insist on good patient feedback for revalidation, which could stimulate better local care for children.

The Government's reforms have largely focused on shifting the leadership for the commissioning and delivery of services from the centre to local areas. The Department of Health has a diminishing role in sharing knowledge and expertise and no longer acts as the 'system leader' for child health.

However, standards and thresholds for quality of care are still required to ensure that localism does not result in knowing or unknowing disregard by commissioners for quality standards and guidance.

The principles for commissioning (see box below) came out of the event held in September 2011. Such a system will support localism and the implementation of locally determined quality services.

## Recommendations

- Health and wellbeing boards should establish a specialist subgroup to agree and oversee responsibilities for commissioning integrated children's, young people's and family health services across a local area. This may be the existing children's trust, where this has been effective.
- The Joint Strategic Needs Assessment and joint health and wellbeing strategy should capture the needs of children and young people. Standardised data should be collected in order to monitor physical and mental health and well-being indicators within and between areas.

## Principles for commissioning a quality children and young people's health service

- Children and young people must be at the core of commissioning and service planning decisions.
- New commissioning arrangements are built around the needs of children, young people and their families, not organisational structures or staffing hierarchies.
- Child health services are designed across collaborative pathways of care, drawing on health expertise across the system, including in local authorities.
- Commissioning decisions aim to get the most out of resources and expertise in the system.
- Commissioning, joint working, monitoring and training act to improve care and efficiency and improve outcomes across a health economy by preventing hospital admissions and reducing length of stay and pressure on more expensive services such as urgent and emergency care.
- Children and young people's health and public health services are developed within an outcomes-based framework guided by quality standards and guidance set and monitored by the NHS Commissioning Board, Public Health England, National Institute for Health and Clinical Excellence (NICE) and other national professional bodies.

- The NHS Commissioning Board should support and encourage clinical commissioning groups and local authorities through the proposed subgroups to jointly commission child health and child public health services against clearly identified and consistent needs assessment.
- The Government needs to be explicit about where accountability lies for child health and child public health, and how shared outcomes between the NHS and public health outcomes frameworks will be monitored, measured and incentivised.
- The Government should develop an Outcomes Framework for children and young people that cuts across all health-related (NHS, social care and public health) and non health-related (education, youth justice, police, children's services) services to make it clear how different sectors contribute to improving overall outcomes.
- The Government must clarify which part of the system will be responsible for commissioning specialist safeguarding professionals in the health service and ensure that safeguarding is integrated within all commissioning decisions.
- The Government must invest to build capacity of commissioners in the NHS and local authorities to commission children's, young people's and family-centred health services.
- Budgets should be aligned between the various commissioning bodies to help make the most of resources and expertise across the system.
- The Department of Health must ensure that a body or structure is responsible for monitoring and measuring quality of services and transition of children and young people from one part of the system to another, including interfaces with education and social care. This could be locally through the health and wellbeing board or through the local arm of the NHS Commissioning Board.
- Young people must have an opportunity to influence their own care within the principles of choice, as well as be included proportionately in representative forums to shape and design services for children and young people.
- The NHS Commissioning Board should conduct a modelling exercise to identify how the changes to GP practice boundaries and the setting of clinical commissioning group boundaries might affect commissioning of both health and local authority services. This exercise should take into consideration those living within an area but not registered with a GP.
- The NHS Commissioning Board should incentivise GPs as providers to improve the quality of primary care for all age groups, through benchmarking, and include children and young people with chronic conditions in local incentive schemes, as well as promote research to improve the evidence base for interventions. There should also be consideration given to the increasing child population and the increase in the numbers of children with complex needs requiring expensive packages of care.
- The Government must urgently clarify how health services for looked after children will be commissioned and provided, particularly for those with complex health or severe behavioural needs who may be placed out of their local areas. Standardised quality of services is required irrespective of locality.

**“Budgets should be aligned between the various commissioning bodies to help make the most of resources and expertise across the system.”**

# Integrated services

We welcome the Government's emphasis on integration following the pause of the Health and Social Care Bill and the NHS Future Forum's recommendations. Evidence shows that integrated care improves the quality of services by connecting services across a whole pathway. It improves patients' experiences and outcomes and results in efficiency savings.

Investing in whole pathways of care – including prevention and early intervention within the NHS and with local government services, including social care, youth justice and education – will improve outcomes and reduce pressure on public services in the long term.

Under the new system, clinical commissioning groups will have a duty to promote integrated health and social care, clinical senates will

include experts to support better integration of services, and Monitor (previously solely an economic regulator) will be required to support delivery of integrated services where this improves care or efficiency. However, it will take time for professionals to learn to work in more integrated ways across multi-professional boundaries.

## Recommendation

- The NHS Commissioning Board and Monitor should be flexible to allow clinical commissioning groups and local authorities to develop locally appropriate solutions to strengthen integrated working focused on addressing the needs of children and young people.

### Case study: Community Children's Health Partnership

The Community Children's Health Partnership is a legal partnership between North Bristol Trust and Barnardo's, created in 2007 to address service fragmentation and improve access to child health services for the most vulnerable families, as measured against an agreed outcomes framework.

It encompasses the full range of child and adolescent mental health services; health, drug and alcohol teams; learning disability/mental health teams; youth offending health team; and community child health services, including community paediatricians, health visitors, school nurses, speech and language therapists, occupational therapists and physiotherapists.

The partnership operates under a set of core values that are part of the induction and appraisal process for all staff and a service users' charter that guides practice and decision making.

Outcomes have been:

- reducing waits for initial appointments
- achieving eight-week waits for all community paediatricians
- increasing breastfeeding rates from 27 per cent to 32 per cent in Bristol's most deprived wards
- training more than 80 per cent of staff in service user participation
- introducing a new management structure that reduced professional silo working.

For more details, visit [www.nbt.nhs.uk/cchp](http://www.nbt.nhs.uk/cchp)

# Any Qualified Provider

It is not clear the extent to which the Any Qualified Provider (AQP) policy will impact upon children's services and there may be unintended consequences when this is implemented. The Department of Health requires primary care trusts (PCTs) to identify three or more community or mental health services in which to implement in AQP 2012/13.

The child health services on the list include psychological therapies, continence services, diagnostic tests closer to home, wheelchair services and podiatry services. These services are in high demand and if supply goes up levels of referrals will need to be monitored to ensure needs are met and to avoid over-prescription for services.

The services that have been highlighted for AQP, like most child health services, are intertwined with other services. Splitting the provision of services may make an integrated care pathway more complex. There will need to be a single coordinating professional or body responsible throughout the life of a child to help manage services provided by different organisations.

The voluntary sector, alongside other providers, must be able to take advantage of the AQP policy because often it is voluntary organisations that ensure the patient voice is heard.

**“There will need to be a single coordinating professional or body responsible throughout the life of a child to help manage services.”**

## Recommendations

- Local commissioners will need the freedom to decide how best to implement the AQP policy in order to improve patient care. Commissioners implementing the AQP policy should incorporate requirements in providers' contracts to improve integrated care and cooperation with other providers in the care pathway. Monitor should include a requirement for integrated working (for example, sharing of information) in its licensing regime.
- The AQP policy should only be used for child healthcare services where there are clear benefits to patients. Where AQP is used, one professional or body must be accountable for ensuring coordinated, high-quality and seamless care across providers in a care pathway.
- Investment should be shifted towards prevention and early intervention services, which will directly benefit children and young people and indirectly reduce long-term pressure on the health service, such as in the management of complex or specialist medications or appliances. When implementing the AQP policy, commissioners will need to include prevention and early intervention elements within contracts.



# Payments and incentives

The current tariff system that pays the health service per activity (Payment by Results) does not cover care across whole pathways or incentivise action on prevention and early intervention.

A tariff system for integrated services is required to enable providers to be paid across a pathway of care. It should be based on best practice, not average cost, with a clearly defined set of quality expectations and with scope for additional quality improvements. It should also incentivise innovation.

**“A tariff system for integrated services is required to enable providers to be paid across a pathway of care. It should be based on best practice, not average cost.”**

## Recommendation

- The Government and Monitor should develop tariffs that allow for local flexibility, provide incentives for prevention and early intervention and cover whole pathways of care, particularly for long-term conditions.

# Workforce

There have been significant improvements in workforce capacity and skill mix within child health services over recent years. Clinical engagement and leadership are working more effectively as a result of investment and professionals have a greater understanding of their day-to-day roles in child health. However, local authority budget cuts and NHS efficiency saving targets mean that child health lead posts, including for safeguarding/child protection, are being absorbed into joint roles with adult services. As children and young people's health services are distinctively different from adult services, the two roles should not be merged.

Delegates at the event held in September 2011 reported that the lack of focus on child health during the reforms and recent clustering of strategic health authorities (SHAs) and PCTs is reducing morale and pushing the skilled and experienced staff, who could best manage reform and innovate in the new structures, into new roles or out of the NHS.

The proposals to radically change the arrangements for education and training through the creation of Health Education England are, in principle, sound because they enable staff across specialties to train together. However, the funding and placement arrangements are not clear. Additionally, the proposals for providers, particularly under the Any Qualified Provider policy, could risk leaving gaps in availability of more complex training placements (such as community-based medical specialties) which could adversely affect the capability of the paediatric workforce.

The changes to the NHS and an increased focus on clinical commissioning and care closer to home has stimulated consideration of the child health experience of GPs. The RCPCH and the Royal College of General Practitioners (RCGP) are working with the medical deaneries to develop improved training for both GPs in child health and paediatricians in primary care.

## Recommendations

- The Department of Health should communicate the need to keep the child and adult lead roles separate and the importance of maintaining child health expertise within commissioning.
- As part of the development of Health Education England, the particular needs of an integrated workforce across children's health services should be considered. This should include modelling skills needs and developing a strategy that builds the workforce of the future and improves pre-service and in-service education and training, including child health training for GPs.

**"The lack of focus on child health during the reforms... is reducing morale and pushing the skilled and experienced staff out of the NHS."**

# Safeguarding

Investment in safeguarding, including child protection training and supervision, has improved the confidence and competence of health staff at all levels. However, there is evidence that the system may be losing these skills in the current changes and the gains and experience achieved to date will be lost. An Association of Directors of Children's Services survey shows that more than one in five designated nurse or doctor posts for children were vacant in 2011 and these rates have increased from 2009.<sup>10</sup>

Safeguarding and child protection are major public health issues. Any failure to identify problems early and intervene at the right time is not only potentially disastrous for the child but costly to the wider community. Health professionals need clear guidance during the transition period to protect and exploit existing expertise among specialist safeguarding professionals in order that the new systems are robust and effective.

Safeguarding is a specialist field of expertise, the necessary knowledge and skills of which are not commonly found among generic health and social care professionals. There should be recognition of the need for these skills in the future and a succession plan which enables development for them to be an integral part of workforce development and leadership within the health service.

The role of local safeguarding children boards is still unclear under the NHS reforms and implementation of the Munro review. We presume that the anticipated accountability framework will clarify the arrangements and future ways of working to ensure effective integration of safeguarding expertise across the health and local authority economy.

## Recommendations

- The Department of Health should support SHAs to monitor and act upon vacancy rates for safeguarding professionals and non-compliance with statutory guidance within the health service during the health reforms transition.
- Clear accountabilities and contractual arrangements for obtaining and acting upon advice from designated professionals, as well as demonstrating knowledge and understanding of safeguarding processes, responsibilities and accountabilities, should be part of the authorisation process allowing clinical commissioning groups to operate.
- Local providers and commissioners should maintain and support sharing and learning networks for named and designated professionals (such as those provided by SHAs) through the local arms of the NHS Commissioning Board.

**"Any failure to identify problems early and intervene at the right time is not only potentially disastrous for the child but costly to the wider community."**

# Health visitors

Child health teams welcome the increased focus on preventative and safeguarding services through the health visitor programme and see the importance of a skilled workforce that is fit for purpose. There is much clear evidence that investment in early years is crucial for long-term health, and the Department of Health-sponsored e-learning programme is an important tool for all working with young children and families.

The absence of any additional funding for the health visiting implementation plan means that good multi-agency early years' teams in some areas are being dismantled to fund new health visitor posts. We are concerned that overall investment may fail to increase in early years in support of the Healthy Child Programme and simply switching resources to defined posts will not result in a tangible improvement in outcomes.

Child health teams welcome more local autonomy to improve systems further and achieve outcomes through the development of multi-professional teams. In particular, they favour investment in cost-effective interventions such as family nurse partnerships.

In the absence of additional funding, we also have concerns that the focus of the programme and resources on children under five years may reduce provision for older children and young people, particularly support and early help for adolescents with healthcare needs.

Striking evidence from community providers has shown the positive impact multi-professional teams can have on child health outcomes.<sup>11</sup>

In one professional's words, "Let's not go back in time, this is a priority as it [the health visitor programme] means taking money away from other priority services."

## Recommendations

- In the absence of additional funding for the health visitor programme, the Government should ensure that recruitment of health visitors does not dismantle effective multi-disciplinary/professional teams that address prevention, early intervention and quality joined up care for children aged 0 to five years. A revised framework could be devised for these multi-professional teams to help local commissioners.
- The target for health visitors should focus on outcomes in line with the Public Health and NHS Outcomes Frameworks. Indicators that measure school readiness and speech development could be used to measure medium-term impact.
- The Government should encourage local areas to flexibly recruit qualified multi-professional staff to meet local needs as identified in the Joint Strategic Needs Assessment and through the joint health and wellbeing strategy.
- Commissioning 0 to five child public health, including health visitors, should be the responsibility of local authorities from April 2013 along with the rest of the public health responsibilities to ensure integration. Under current plans, the NHS Commissioning Board will commission these services until 2015. A ring-fenced budget would protect delivery of improved outcomes for children.

**"Child health teams see the need for more local autonomy to improve systems further and achieve outcomes through the development of multi-professional teams."**

## Case study: Family nurse partnerships

County Durham and Darlington was one of ten pilot sites for family nurse partnerships, with a pilot programme running from 2007 to 2010. The family nurse partnership is a preventive, intensive home visiting programme for vulnerable first-time teenage mothers. It begins in early pregnancy and ends when the child reaches the age of two.

A family nurse was based within a children's centre in each of six locality areas and 190 young, first-time mothers were recruited to the programme across the localities. The family nurses were drawn mainly from health visiting and midwifery and received additional training to equip them for the new role.

Family nurses used programme guidelines, materials and practical activities to work with the mother, as well as the father and wider family, on understanding their baby, making changes to their behaviour, developing emotionally and building positive relationships.

Outcomes included improvements to antenatal health, with 91 per cent of babies born with a birth weight over 2.5kg, and improved child health and development, with 97 per cent of children having age-appropriate development and 94 per cent having age-appropriate speech and language development.

There were also improved economic outcomes for the family. When recruited to the programme, 63 per cent of mothers were not in employment, education or training. At the end of the three-year pilot, 55 per cent of mothers were in employment, education or training.

Family nurses reported a strong parent-child attachment, increased parenting awareness and positive attitude towards parenting and family relationships.

The in-depth relationship the nurses developed with their clients and their therapeutic communication skills enabled them to connect deeply with the motivations and 'heart's desires' that all first-time parents have, guiding them through what is often a difficult life transition.

Family nurses come from a variety of backgrounds including health visiting, midwifery, school nursing and mental health. Across the country the minimum size of a family nurse partnership team is four nurses and a supervisor and each nurse has a caseload of 25 families. The teams work closely with universal maternity and child health services and children's centres.

Early evaluation across the pilot sites in England looks promising and the programme is being expanded to 13,000 places by 2015. There are currently 6,000 places and by April 2012 there will be a family nurse partnership team of family nurses in over half of all local areas in England.

More information on the family nurse partnership programme can be found on the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk)

Read the full case study at [www.c4eo.org.uk](http://www.c4eo.org.uk)



# Transition to adult services

The Special Educational Needs and Disabilities green paper 2011 aimed to standardise the age of transferring young people with specific long-term needs to adult services at 25 years. In order for this to happen, more work is required to ensure appropriate alignment and communications between paediatric/adolescent and adult services.

It is not clear how the process of standardising the age of transition will take place and how the arrangements for young people receiving services such as acute services, that are often only provided as paediatric services up to the age of 16, will work.

GPs need to be more involved in the transition process. It must be appreciated that there may be no equivalent adult services for children with complex needs or long-term medical conditions, and GPs will be the health professionals picking up overall responsibility for the care of these young people.

**“There may be no equivalent adult services for children with complex needs or long-term medical conditions, and GPs will be the health professionals picking up overall responsibility.”**

## Recommendations

- Child and adult health services should be designed and commissioned together, with greater alignment and additional support provided to patients to ensure the transition to adult services is as smooth as possible. Alignment between child and adult services should also increase young people's voices as service users within the health system, ensuring their representation and rights alongside procedures for their feedback and complaints.
- The Government must clarify how it intends to standardise the age at which health, social care and other services are provided to children and young people. Further details are needed regarding the funding, accountability and commissioning arrangements for these services.

# Information and data

Over recent years some PCTs and local authorities have developed more open processes to share data and information across organisations, such as the Multi-Agency Safeguarding Hub in Devon<sup>12</sup> (see case study on page 19). However, this is not universal and in many cases professionals have not been clear about their roles in completing various data management systems such as the Common Assessment Framework.

Access to shared systems has been patchy, for example between acute and community services, school nurses and health visitors, and GPs, as systems are often standalone. There is some evidence that a tightening of budgets is resulting in more limited IT investment and this may have a negative impact on work to align local authority and healthcare IT systems. Extra IT capacity might be needed to improve integrated working.

The welcome increase in the evidence and information available for interventions such as family nurse partnerships through audits does not always contribute directly to improving commissioning and provision of services.

It is important to provide quality, accessible information about services to children and young people. This is essential to ensure they are able to make informed choices about their own health and well-being.

**“Quality, accessible information about services to children and young people is essential to ensure they are able to make informed choices.”**

## Recommendations

- NHS bodies and local authorities should design and agree data systems and sharing arrangements with clear governance procedures to ensure that information precedes the patient, and with clear contractual requirements for data interfaces to work between providers.
- The National Child Health Data Set should be collected by all providers/commissioners, and the set must be expanded to facilitate monitoring and improvement of public health outcomes. To enable this to happen, the data and information systems of local authorities and the NHS must be aligned.
- Child health data collection and data quality should be overseen by the NHS Commissioning Board in partnership with Public Health England.
- Existing data should be better used to monitor needs and progress. Data should be collected once, with systems for sharing to avoid placing unnecessary burdens on patients, families, the NHS and local government systems.
- Targeted and accessible information should be provided to children and young people regarding their health and well-being and related services. This will help to engage children and young people. Issues regarding parental consent need to be tackled to ensure relevant and appropriate help is available.
- It will not be sufficient to measure progress solely through the Public Health and NHS Outcomes Frameworks. There will be significant time lags for achieving health improvements for children and young people as they move into adulthood and therefore progress should be measured through process/output indicators.

## Case study: Multi-Agency Safeguarding Hub<sup>12</sup>

In 2010/11 around 620 children and young people in the county of Devon were in care and 431 had a child protection plan. In 2010 a further 4,318 were defined as children in need.

A range of different agencies were responsible for safeguarding children. They operated across local authority boundaries and lacked a unified relationship. To address this, the Multi-Agency Safeguarding Hub (MASH) was set up, aiming to improve the quality of information sharing and decision making and to reduce the potential risk to children and young people.

Made up of the probation service, the youth offending team, health professionals and staff in individual schools, the MASH is a team of people who continue to be employed by their individual agencies, but who are co-located in one office. This was seen as the most effective way to build relationships, trust and understanding between agencies so that staff could be confident about sharing information.

They can engage with the MASH in three ways, by:

- seeking information, advice and guidance regarding a safeguarding concern before deciding whether or not to make a referral
- responding to a request for information about a case that has been referred to the MASH
- taking action as a result of an outcome from the MASH.

Protocols govern how and what information can be released from the intelligence unit to operational staff.

It is considered too early to make a definitive assessment as to whether the model offers good value for money. However, a National Foundation for Educational Research case study looked at its impact and outcomes. It found that the MASH:

- was seen to reduce the risk of a serious case review being required, or any such review finding that poor information sharing contributed to a child being harmed
- has contributed to cultural change in terms of different agencies being willing to share information
- has highlighted gaps in information or practice among partner agencies, which the specialist teams were then able to address with the professionals concerned
- lead to better decisions when assessing referrals and improved responses to referrals, resulting in increased early intervention
- resulted in greater efficiency due to faster responses and more informed teams.

# Conclusion

Unless there is increased investment in prevention and early intervention, England will fail to make progress on the child health indicators that leave us trailing behind our European counterparts and the demands on the health service and public services will grow.

With health and local government reforms underway, there must be a renewed focus on children and young people's health if we are to avoid losing some of the gains that have been made in this area over the last few years.

Improving child health must be prioritised over organisational processes and structures. Joint working is required to make progress and aligning budgets and improving IT and information systems will help to make this happen. The NHS Commissioning Board will have to act quickly to model the impact of the changes on children's and young people's health, engaging children and young people in the process. Sharing of good practice must continue, along with development of the evidence base for effective and efficient services.

Making services work for children and young people has to be a priority for all governments to ensure a healthy and confident population that can contribute to economic success and reduce costs now and in the future.

## Next steps – events in 2012

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The NHS Confederation and the Royal College of Paediatrics and Child Health will continue to monitor the situation regarding child health in 2012, including the implementation of the recommendations raised in this report. With others, we will be conducting regional workshops with child health professionals within commissioning and provider organisations in order to focus on the core elements required to enable children's health to benefit from the changes to the NHS.

For more details of our work in this area and details about the events, please contact either:

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# Children and young people's health – where next?

The health and local government reforms coming into force in England will significantly affect how child health services will be commissioned and delivered.

Significant improvements in child health have been made over the last five years, but unless children's and young people's needs are brought into focus, the current reforms have the potential to undo much of this good work.

This report outlines the priorities for child health as the NHS and local government reforms are implemented.

Developed in partnership with the Royal College of Paediatrics and Child Health, it includes the views from child health professionals in the NHS and local government. It also takes into account the views expressed to the NHS Confederation from clinicians, managers, commissioners and providers across the NHS.

This report is published alongside a paper, *Engaging and involving children and young people in health services*, which looks at giving children and young people a louder voice in influencing health services.

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